Senate File 2340 - Introduced

SENATE FILE 2340
BY COMMITTEE ON HUMAN RESOURCES

(SUCCESSOR TO SF 2221)

A BILL FOR

An Act relating to Medicaid managed care resolution of payment and notice of change.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. MEDICAID MANAGED CARE —— RESOLUTION OF PAYMENT AND NOTICE OF CHANGE. The department of human services shall adopt rules pursuant to chapter 17A and shall amend all Medicaid managed care contracts, to require all of the following:

1. For Medicaid provider claims ultimately found to be incorrectly denied or underpaid through an appeals process or audit, a managed care organization shall pay, in addition to the amount determined to be owed, interest in an amount equal to eighteen percent per annum on the total amount of the claim ultimately authorized as calculated from fifteen days after the date the claim was submitted.

2. A managed care organization shall provide written notice to all affected individuals at least sixty days prior to a change in administrative processes or procedures relating to the scope or coverage of benefits, billings and collections provisions, provider network provisions, member or provider services, prior authorization requirements, or any other terms of a managed care contract or agreement upon which an affected individual relies under Medicaid managed care. A managed care organization may comply with the requirement of providing written notice under this subsection by posting such written notice on the managed care organization's internet site.

3. A managed care organization shall pay, contest, deny, or settle a claim, in whole or in part, within forty-five business days after receipt of the claim. If a claim is contested or denied, the managed care organization shall, with as much specificity as possible, identify the claim or portion of the claim affected, provide an explanation and the reasons for contesting or denying the claim, and provide the claimant with instructions for appealing the contested or denied claim.

4. A managed care organization shall complete the internal review process for any claim submitted within ninety business days of receipt of the request for internal review. If the first level of review is not completed within the ninety-day

period, the claim shall be subject to contested case review pursuant to chapter 17A, notwithstanding the fact that the claimant has not exhausted the managed care organization's internal review process and received a final written determination from the managed care organization.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill requires the department of human services (DHS) to adopt administrative rules and amend all Medicaid managed care contracts to provide for compliance with certain notice and payment requirements.

The bill requires an MCO to provide written notice to all affected individuals at least 60 days prior to a change in any term of a managed care contract or agreement upon which an affected individual has relied under the Medicaid managed care program. An MCO may comply with the notice requirements by posting the written notice on the MCO's internet site.

The bill requires an MCO to pay, contest, or deny a claim, in whole or in part, within 45 business days after receipt of the claim. If a claim is contested or denied, the managed care organization shall, with as much specificity as possible, identify the claim or portion of the claim affected, provide an explanation and the reasons for contesting or denying the claim, and provide the claimant with instruction for appeal of the claim.

The bill requires an MCO to complete the internal review process for any claim submitted within 90 business days of receipt of the request for internal review. If the internal review is not completed within the 90-day period, the claim is subject to contested case review pursuant to Code chapter 17A, notwithstanding the fact that the claimant has not exhausted the managed care organization's internal review process and received a final written determination from the MCO.